Multi-Payer Patient-Centered Medical Home Stakeholder Group

Wednesday, May 18, 2016, 2:30 - 4:30 pm
Room 1524, State Capitol
Senator Mike Gloor

Minutes

A. Welcome - Senator Gloor
Anti-Trust Statement was read

Introductions:
Senator Mike Gloor - District 35
Margaret Buck, L.A. to Sen. Gloor
Dr. Tony Sun - United HealthCare
Dr. Bob Rauner - NAFP
Dr. Steve Lazoritz - Arbor Health Plan
Margaret Brockman - Office of Rural Health
Matt Wallen - DHHS
Dr. Jason Dees, Centene Nebraska Total Care
Ryan Sadler, Centene Nebraska Total Care
Bruce Greenstein, The Compliance Team
Steve Simmerman, The Compliance Team
Dr. Mike Horn, UHC
Laurilee Rubel, Well Care
Dr. Ken Schaffer, Uninet, Kearney
Judy Martin, NDHHS
Rocky Thompson, NDHHS
Bryson Bartels — NDHHS
Liz Simon, NAFP
Jina Ragland, NMA
Sara Hotovy, Healthy Lincoln
Charlene Dorsey, NAND
John Wendling - Magellan CEO
Krissa Delka, Revenue Committee Clerk, Senator Gloor's office
J.P. Sabby, NDOI

Conference call participants:
Amy Behnke, HCAN
Deb Esser - BCBS NE
Nancy Davis, Centene Nebraska Total Care
Nick D'Ambra, Well Care
Kimberly Wooten, Well Care
Dr. Dale Michels

B. Presentation
The Compliance Team
Bruce Greenstein presented information about The Compliance Team's accreditation for PCMH.

C. Can the stakeholder group find a home?
Question: Senator Gloor posed the question of where does everyone see PCMH Stakeholders in the future now that he is term limited?
Matt Wallen, DHHS, representing CEO Courtney Philips, commented on NDHHS discussions of where to house PCMH stakeholder within HHS, budget and resources, competing initiatives. He asked for feedback from the Stakeholder Group.
Dr. Bob Rauner suggested that the medical societies are willing to help with resources but they have no convening authority so NDHHS is definitely needed to keep the forum going.
Dr. Ken Schaffer commented that facilitation is what is needed.
The discussion was interrupted for the scheduled 3:30 presentation by Lisa Dulsky Watkins from the Milbank Memorial Fund.

D. CPC+ - Dr. Lisa Dulsky Watkins - Milbank Memorial Fund

- Remote presentation of CPC+ Program
- Discuss Medicare Payment Reform effort

Questions: Does eligibility for CPC+ require a statutory mandate or if our voluntary agreement would suffice? Answer: Our agreement would certainly met eligibility requirements and in fact, CMS is looking to expand into states like Nebraska with a multi-payer initiative.

Question: Are providers required to have NCQA certification. Answer: No, not specifically NCQA.

Question: Medicaid participation? Answer: Medicaid is a very important player but Lisa is still working on getting a definitive answer as to whether that means they have to be a full applicant or just give a letter of support or intent.

Question: Will the state have to have the dominant payer, BCBS, in the application in order to create enough statewide coverage for CMS to approve an application? Answer: Yes but other states are also finding hesitation in payers to be the first one to participate.

Dr. Watkins stated that she would be willing to connect payers in Lincoln with CMMI officials.

Dr. Tony Sun stated that UHC has participated in CPCI in other markets in the country and agrees that this opportunity is extraordinary. He voiced concern about having a CPTI organization in the state and how that would affect a CPC+ application. He also encouraged ACOs to comment to CMS about being able to participate.

Announcement:
Margaret Bockman, Office of Rural Health is planning a PCMH Workshop in Scottsbluff. NE. The Academy of Family Physicians will assist with planning and promote the event. She is looking for financial assistance/sponsorships to assist with the costs of workshop. She's looking at August for the event.

E. Next Meeting?

- The next PCMH Stakeholder meeting will be likely toward the end of summer or September.
- Adjourned at 4:15 pm.

Innovations in Patient Centered Medical Home Adoption

A Presentation made by

The Compliance Team

TheComplianceTeam®
Exemplary Provider® Accreditation

Today's Discussion

- Who is The Compliance Team
- Recognition – Says Who?
- Recognition and Market Failure
- What We Hear from Providers and Why Now is the Time to Get Involved
- How it Will Work Going Forward - Standards

PCMH Recognition

- Push for higher quality and cost control provided focus on PCMH
- Value Based Purchasing is giving greater emphasis to PCMH as strategy
- Plans, States, and Health Systems declare which organizations can provide PCMH recognition for practices

The Compliance Team, Inc.
Exemplary Provider™ Accreditation Program

"Every patient deserves exemplary care."
The provider must focus on what matters most to Patients .....

Safety, Honesty & Caring®

Who is The Compliance Team, Inc.

- 22 Year Old National Healthcare Accreditation Organization with CMS recognition
- RN owned, WBENC certified
- First year in business contracted with multiple managed care entities to do over 5,000 credentialing visits
- 1998 Launched DMEPOS Accreditation Program
- 1999 BCBS of NC was first to recognize TCT Program
- 2006 Received CMS Deeming Authority, Part B DMEPOS
- 2014 Received CMS Deeming Authority, Part A RHC

The TCT EP Program and process

Accreditation Simplified

Simplification leads to clarity and clarity allows the provider to focus on what matters most……..Safety, Honesty, Caring !

TCT and PCMH

- So much emphasis on market dominators
- Accreditation/Recognition done as one size fits all
- The other organizations that entered the recognition area adopting the same practices
- TCT instead focused on small and medium sized providers, rural clinics and physicians

What We Heard

- *Burdensome*
- *Rigid*
- *Expensive*
- *Overwhelming*
- *Takes away from patient care*
- This is when we knew it was time to offer a PCMH accreditation program
- We focus on the patient, the care and look at day to day operations – this, we think, is the winning approach

What Does the PCMH Program Look Like for TCT?

- User Friendly; Operationally Driven
- Focuses on Simplification of Standards and Processes
- Removes the need for outside consultants: no need for interpretation – practices can do it on their own
- Is more likely to get buy-in and accomplish what the program is designed to do

What's Our Approach

- Self Assessments
- Checklists (Educational, CMS approves)
- Templates (in the future)
- On Site Visits – with real people who know accreditation, clinics and physicians and office managers

So, What Does this Mean?

- It is Dictating Rigidity or…
- Catalyzing Improvement with what and how
  - Comprehensive Care
  - Patient Centered
  - Coordinated Care
  - Accessible Services
  - Quality and Safety

Every Patient Deserves Exemplary Care Thru SAFETY-HONESTY-CARING®

- Safety – Risk Management, Infection Control, Equipment Management
- Honesty – Corporate Compliance, Administration, Billing, Human Resources, Regulatory
- Caring – Patient Services, Diagnostic Services, Pharmaceutical Management

Operational Excellence Leads To Clinical Excellence

- HR 1.0 Hiring, orienting, and training of all employees
- INF 1.0 Protect the patient and staff from the spread of infection
- EQP 3.0 All sterilization and CDC 2008 guidelines

Corporate Compliance

- COM 1.0 Clinic/Practice has a Corporate Compliance Plan
- COM 4.0 Clinic/Practice has policies and procedures regarding disciplinary and corrective action to be taken when fraudulent behavior is suspected
- COM 5.0 Clinic/Practice verifies the license of all licensed personnel

PCMH

- ADM 1.0 Clinic/Practice provides advanced access to its patients (including Hospital Discharge Planners, churches, public health agencies, other healthcare professionals including pharmacists, LTC's, rehab, and community clubs)

- ADM 2.0 Clinic/Practice has agreements with other providers to meet the needs of their patients when closed

- ADM 5.0 Clinic/Practice is team based in its patient care approach both inside as well as providers outside the Clinic/Practice with direct involvement in patient care

PCMH

- ADM 9.0 Clinic/Practice meets requirements related to meaningful use

- ADM 10.0 Complete Medical Records includes of preferred language for healthcare discussion, including family member or individual part of the care circle, pharmacy, and overall assessment of the status and health care needs of the patient to an individualized care of plan (not all inclusive list)

- ADM 10.0 Complete Medical Records includes legal status if receiving behavioral services and a BIMS screening if 65 or over or cognitive symptoms

PCMH

- ADM 12.0 Clinic/Practice has a plan for improving efficiency in care delivery

- QI 1.0 Clinic/Practice maintains a continuous quality improvement plan and conducts an annual evaluation of its overall program including an audit tool to evaluate compliance with processes relating to meeting the guiding principles of PCMH in the care of all patients

- QI 1.0 Clinic/Practice QI Plan includes multiple elements such as HEDIS and EPSDT as required by State and Payer

PCMH

- QI 2.0 Clinic/Practice collects data for patient satisfaction, experience, and dissatisfaction

- Patient Protection Zone™ in standards notifies area of extra patient caution required

- PTS 2.0 The Clinic/Practice looks at the whole person-orientation of the patient including asking the patient about health goals in terms of what they wish to achieve (see standards, not an all inclusive list)

- PTS 4.0 The Clinic/Practice provides patient education and self-management tools and support for patients, families, and caregivers

What Makes The Compliance Team, Inc different?
"Accreditation Simplified"

Electronic Benchmarking to track Patient Outcomes Data and compare to National database, a required CMS standard that others pay extra.

**Provider groups and chains may use Electronic Benchmarking to monitor member performance.*
Reports can be generated to submit to payors for validation of Beneficiary care as it relates to claims payment.

Patient Outcome Results Report - Comparison to National Average

Your Inputs

Customer: The Compliance Team, Inc. **Date Range:** From day one To now **Survey Type:** All Types

Your Overall Results (3 surveys, 24 questions)

	Your Amount	Your Percentage	National Average Percentage
YES	18	75.00	93.79
NO	6	25.00	0.36
N/A	0	0.00	5.86

#	Question	YES Your % / National Avg %	NO Your % / National Avg %	N/A Your % / National Avg %
1	Equipment/supplies were delivered in a timely manner.	100.00% / 92.02%	0.00% / 92.02%	0.00% / 7.48%
2	Equipment/supplies were ready for patient use upon delivery.	66.67% / 93.97%	33.33% / 93.97%	0.00% / 5.79%
3	Received and understood instructions on proper application and use of equipment/supplies.	100.00% / 95.63%	0.00% / 95.63%	0.00% / 4.23%
4	Feel confident to operate/use equipment/supplies.	100.00% / 95.71%	0.00% / 95.71%	0.00% / 3.81%
5	Received info on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons.	66.67% / 94.47%	33.33% / 94.47%	0.00% / 5.03%
6	Response to my questions, problems, concerns were addressed in a timely manner.	33.33% / 82.65%	66.67% / 82.65%	0.00% / 16.97%
7	Satisfied with the equipment or supplies.	66.67% / 95.54%	33.33% / 95.54%	0.00% / 3.78%
8	Satisfied with the service. Would recommend to others.	66.67% / 96.16%	33.33% / 96.16%	0.00% / 3.69%

Main Menu Log Out

PCMH

- PTS 7.0 Clinic/Practice utilizes patient-centered care planning

- PTS 8.0 Clinic/Practice has process for follow-up relating to type of service and patient condition (i.e. appointment reminder, missed appointment, lab/diagnostic results, previous care/screening reminders, etc.)

- PTS 11.0 Clinic/Practice provides continuous coordinated care that is patient centered for all of its patient (i.e. referrals, hospital admin/dc, EPSDT requirement, high risk, etc.)

PCMH

- DRG 1.0 Written policies required for storage, handling, and dispensing drugs & biologicals (schedule, temperature monitoring of fridge, etc.)

- REG 1.0 Clinic/Practice is in compliance with all local, State, and Federal regulatory agencies

- REG 2.A Clinic Practice is in compliance with OSHA blood-borne pathogen standard

- REG 2.B Clinic Practice is in compliance with OSHA TB Standard

Comprehensive Primary Care Plus (CPC+)

Frequently Asked Questions

Q1: What is being announced today?

A1: Today, the Centers for Medicare & Medicaid Services (CMS) announced the launch of a new advanced primary care medical home model called Comprehensive Primary Care Plus (CPC+). CPC+ rewards value and quality by offering an innovative payment structure to support comprehensive primary care. The model is built on the foundation of the Comprehensive Primary Care (CPC) initiative, which began in October 2012 and is scheduled to run through December 31, 2016. CPC+ is a five-year model and will begin in January 2017.

Q2: How will CPC+ support the HHS delivery system reform goals of better care, smarter spending, and healthier people?

A2: Strengthening primary care is critical to an effective health care system. CPC+ will contribute to the goals set by the Administration of having 50 percent of all Medicare fee-for-service payments made via alternative payment models by 2018. Effective implementation of CPC+ will also improve the quality and value of care for Medicare beneficiaries, which is essential to creating a health care system that delivers better care, spends our dollars more wisely, and leads to healthier Americans.

Additionally, CPC+ aligns with priorities outlined by the Office of the National Coordinator for Health IT (ONC) aimed at ensuring electronic health information is available when and where it matters to consumers and clinicians.

Q3: Why is CMS testing CPC+?

A3: CMS believes that through payment reform and practice transformation, primary care in the U.S. can deliver on its value to Americans and our health care system. Practices will be able to build capabilities and care processes to deliver better care, which will result in a healthier patient population. Payment redesign will offer the ability for greater cash flow and flexibility for primary care practices to deliver high quality, whole-person, patient-centered care and lower the use of unnecessary services that drive total costs of care.

In its first year, CPC achieved gross savings and was nearly cost neutral, with positive quality results. These findings came earlier than expected in a model involving significant changes in the delivery of primary care. CPC+ looks to build on these results by offering two tracks with different payment options to better accommodate the diverse needs of primary care practices.

Q4: Who will partner and participate in CPC+?

A4: CPC+ will bring together Medicare with commercial and state payer partners in up to 20 regions around the country to support eligible practices in both tracks. CPC+ targets primary care practices with varying capabilities and levels of experience. In order to participate, all CPC+ practices must have multi-payer support, use Certified Electronic Health Record Technology (CEHRT), and demonstrate other capabilities. Track 2 practices will also be asked to submit letters of support from their health IT vendors, and vendors that intend to partner with practices will memorialize their commitment in a MOU with CMS.

Q5: Where will CPC+ be implemented?

A5: CPC+ will be implemented in up to 20 geographic areas throughout the U.S. The CPC+ regions will be selected based on the locations of the payers that apply. CMS will select regions where there is sufficient interest from multiple payers to support practices that participate in Tracks 1 and 2 of CPC+.

CMS is committed to supporting the development and testing of innovative health care payment and service delivery models throughout the country, particularly in states and regions where there has been a foundational investment. Thus, the seven regions in the CPC iniative will be included in CPC+, if sufficient payers indicate their interest in partnering in CPC+ and propose an aligned approach to CMS. In addition, CMS will give preference to the eight states that have participated in the Multi-Payer Advanced Primary Care Demonstration, as well as states receiving State Innovation Models (SIM) Initiative Model Test Awards, if Medicaid is a participating payer and if sufficient other payers in these states indicate their interest in partnering in CPC+.

Q6: How and when can interested payers submit a proposal to partner with CMS in the model?

A6: CMS will partner with payers across the country that share Medicare's interest in strengthening primary care. A variety of payers, including, commercial insurers, Medicare Advantage plans, states, Medicaid/CHIP managed care plans, and self-insured businesses or administrators of a self-insured group, are invited to respond to the CPC+ Solicitation for Payer Partnership.

Payer Partnership Framework:

- Support practices in both CPC+ tracks;
- Provide enhanced, non-visit based financial support for both Track 1 and 2 practices to allow practices to meet the aims of the care delivery model and provide care management, care coordination, and similar "wraparound" services to all patients, agnostic of payer;
- Offer the opportunity for Track 1 and 2 practices to qualify for performance-based incentive payments;
- Change the cash flow mechanism from fee-for-service to at least a partial alternative payment methodology for Track 2 practices;
- Provide participating practices with practice and member-level data regarding cost and utilization at regular intervals;
- Align quality and patient experience measures with those used by CMS and other payers in the region.

The CPC+ Solicitation for Payer Partnership is available at https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf and must be submitted to CPCplus@cms.hhs.gov by **June 1, 2016 at 11:59pm ET**. Payer proposals will be reviewed by CMS staff to determine the degree to which they align with the CMS approach

Q7: How can practices apply to participate in CPC+?

A7: CMS will solicit applications from practices within the regions chosen after the preliminary payer solicitation round is complete, beginning **July 15, 2016** with applications due by **September 1, 2016 at 11:59pm ET**. Practices will apply directly to the track for which they are interested and believe they are eligible; however, CMS reserves the right to ask a practice that applied to Track 2 to instead participate in Track 1 if CMS believes that the practice does not meet the eligibility requirements for Track 2 but does meet the requirements for Track 1.

In order to participate, all CPC+ practices must have multi-payer support, Certified EHR Technology (CEHRT), and other infrastructural capabilities. When they apply, Track 2 practices must demonstrate additional clinical capabilities to deliver comprehensive primary care.

CPC+ Practice Eligibility Criteria:

Track 1

- Practice structure and ownership information;
- Use of CEHRT;
- Payer interest and coverage;
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities.

Track 2

- Practice structure and ownership information;
- Use of CEHRT;
- Payer interest and coverage;
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while also developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community based resources.
- Letter of support from health IT vendor that outlines the vendor's commitment to support the practice in optimizing health IT.

Further details about the practice application will be available in summer 2016 once the CPC+ regions are selected. Interested practices will submit applications for CPC+ via an online application portal. More details about practice participation in CPC+ is available in the CPC+ Request for Applications (RFA) at https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf

Q8: What is the role of CEHRT vendors in relation to Track 2 practices?

A8: As part of the application process for Track 2, practices will be asked to submit a letter of support from their health IT vendor(s) that outlines the vendor's commitment to support the practice in optimizing health IT. Following the selection of practices for the model, vendors will complete a MOU with CMS that reiterates their willingness to work together with CPC+ practice participants to develop the required health IT capabilities. CMS will not prescribe the technical specifications for any tool/enhancement of the technology or endorse or pay for any health IT vendor or product.

Q9: When will CPC+ start and how long will it last?

A9: The first performance period for CPC+ begins on January 1, 2017.

CPC+ consists of five performance years, per the table below.

PERFORMANCE YEARS FOR CPC+

Performance year	Calendar year
1	2017
2	2018
3	2019
4	2020
5	2021

Q10: What are the major policy differences between CPC and CPC+?

A10: CPC+ builds upon the lessons learned from the CPC initiative, CMS' largest investment in primary care to date. Notable policy changes include:

Size: CPC supports approximately 500 practices in seven U.S. regions (Arkansas: Statewide; Colorado: Statewide; New Jersey: Statewide; New York: Capital District-Hudson Valley Region; Ohio & Kentucky: Cincinnati-Dayton Region; Oklahoma: Greater Tulsa Region; Oregon: Statewide). CPC+ will support up to 5,000 practices in up to 20 regions.

Duration: CPC is a four-year model, launched in 2012, set to end on December 31, 2016. To better account for the time that practice transformation requires, the duration of CPC+ is five years, beginning on January 1, 2017.

Tracks: CPC includes a single model of payment and practice requirements. CPC+ will offer two tracks with care delivery requirements and payment methodologies that advance from Track 1 to Track 2, providing opportunities for participation for primary care practices with varying levels of practice transformation experience.

Care Delivery: In CPC, practices redesign care delivery to deliver a set of Five Comprehensive Primary Care Functions ((1) Access and Continuity; (2) Planned Care for Chronic Conditions and Preventive Care; (3) Risk-Stratified Care Management; (4) Patient and Caregiver Engagement; (5) Coordination of Care Across the Medical Neighborhood). CPC+ maintains this care delivery framework, with slight revisions to these functions ((1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; (5) Planned Care and Population Health). Further, in Track 2, practices will heighten their focus on caring for patients with complex medical, behavioral, and psychosocial needs. Thus, Track 2 practices will have the flexibility to increase the breadth and depth of services offered to beneficiaries.

Medicare Care Management Fee: As with CPC, CPC+ practices will receive a risk-adjusted, prospective, monthly care management fee (CMF) for their attributed Medicare fee-for-service patients. Practices may use this enhanced, non-visit-based compensation to enhance staffing and training to support population health management. CMS will pay Track 1 practices an average $15 per beneficiary per month (PBPM). Track 2 practices will receive an average $28 PBPM, inclusive of a $100 PBPM for an additional highest risk tier to support enhanced services for beneficiaries with complex needs.

Medicare Payment for Primary Care Services: Similar to CPC, Track 1 practices will continue to receive Medicare fee-for-service payments. In Track 2 of CPC+, CMS is introducing a hybrid of Medicare fee-for-service payments and the "Comprehensive Primary Care Payment" (CPCP). The CPCP changes the cash flow mechanism for Track 2 practices, promotes flexibility in how practices deliver care traditionally provided face-to-face, and requires practices to increase the depth and breadth of primary care. Track 2 practices will receive the CPCP, an upfront payment of a portion of their expected Medicare reimbursement for face-to-face Evaluation & Management (E&M) services, on a per capita basis, independent of submitting claims for those services. Reimbursement for face-to-face E&M services for attributed patients will be paid at a commensurately reduced Medicare fee-for-service rate.

Redesigned Incentive Structure: CPC incentivized improved quality and lower total cost of care through shared savings payments calculated at the regional level. Through performance-based incentive payments, CPC+ will encourage and reward practices for their performance on patient experience, clinical quality, and utilization measures that drive total cost of care. The CPC+ incentive payment will be based on performance measured at the practice-level. CMS will pay the incentive to practices at the beginning of a performance year, but will recoup payments made to practices if they do not meet quality and utilization performance thresholds.

Health IT for Advanced Primary Care: Comprehensive primary care requires advanced health IT support for its population-health focus and team-based structure. In CPC, practices worked to build their health IT capabilities. In CPC+, CMS will require Track 2 practices to engage more directly with vendors about model goals and requirements. Additionally, Track 2 vendors will sign a Memorandum of Understanding (MOU) with CMS to outline vendors' commitment to partnering with primary care practices participating in CPC+.

Q11: How will CPC+ measure the improvement in the quality of care for and experience of care by patients?

A11: This model aims to improve the quality and experience of care that beneficiaries receive and decrease the total cost of care. To assess quality performance and eligibility for the CPC+ performance-based incentive payment, CMS will require Track 1 and 2 practices to annually report electronic clinical quality measures (eCQMs) and patient experience of care measures (Consumer Assessment of Healthcare Providers & Systems [CAHPS]). eCQMs must be reported at the practice-site level and are specified to include all practice population patients, regardless of payer or insurance status. CAHPS surveys will be administered by CMS or its contractors to patients in practices in Track 1 and Track 2. In future years, Track 2 practices may also use a patient reported outcome measure survey.

Q12: How will primary care practices be paid in CPC+?

A12: CPC+ practices will receive a risk-adjusted, prospective, monthly care management fee (CMF) for their attributed Medicare fee-for-service patients. Practices will use this enhanced, non-visit-based compensation to augment staffing and training in support of population health management and care coordination. Track 1 practices will receive a CMF that averages $15 per beneficiary per month (PBPM) to support their transformation efforts. Track 2 practices will receive an average of approximately $28 PBPM, including a $100 PBPM for a highest risk tier to support the enhanced services beneficiaries with complex needs require.

CPC+ Care Management Fees

Risk Tier	Attribution Criteria	Track 1	Track 2
Tier 1	1st quartile HCC	$6	$9
Tier 2	2nd quartile HCC	$8	$11
Tier 3	3rd quartile HCC	$16	$19
Tier 4	4th quartile HCC for Track 1; 75-89% HCC for Track 2	$30	$33
Complex (Track 2 only)	Top 10% HCC OR Dementia	N/A	$100
Average PBPM		**$15**	**$28**

In Track 1, practices will also continue to receive regular Medicare fee-for-service payments for covered services. In Track 2 of CPC+, CMS is introducing a hybrid of fee-for-service and CPCP. The CPCP will pay for covered E&M services, but allows flexibility for the care to be delivered both in and outside of an office visit. Track 2 practices will receive a percentage of their expected Medicare E&M payment upfront in the form of a CPCP and a reduced fee-for-service payment for face-to-face E&M claims. In an effort to recognize practice diversity in readiness for this change in payment, CMS will allow practices to move to one of these final two proposed hybrid payment options (40% or 65% CPCP with 60% or 35%, FFS), at their preferred pace by 2021, pursuant to the options shown in this table:

CPCP%/FFS% options available to practices, by year

2017	*2018*	*2019*	*2020*	*2021*
10%/90%				
25%/75%	25%/75%			
40%/60%	40%/60%	40%/60%	40%/60%	40%/60%
65%/35%	65%/35%	65%/35%	65%/35%	65%/35%

Q13: Why is CMS testing a performance-based incentive payment in CPC+, rather than shared savings?

A13: The intent of the performance-based incentive payment is the same as traditional shared savings: motivate providers by rewarding outcomes that reduce beneficiaries' total cost of care. However, unlike retrospectively paid shared savings measured at the region-level, the CPC+ performance-based incentive payment focuses on quality and utilization measures that are calculated at the practice-level and are actionable for primary care practices.

Q14: What are the main design features of the CPC+ care delivery model?

A14: In CPC+, practices will be guided by Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; (5) Planned Care and Population Health. In Track 2, the practices will heighten their focus on caring for patients with complex medical, behavioral, and psychosocial needs. Thus, Track 2 practices will increase the breadth and depth of services offered, as well as inventory resources and supports necessary to meet their psychosocial needs, as appropriate. Because comprehensive primary care requires advanced health IT support for its population-health focus and team-based structure, CMS will require Track 2 practices to engage directly with vendors about model goals and requirements.

Q15: What learning and technical assistance supports will CPC+ offer to participating practices?

A15: CPC+ will offer participating practices a variety of learning opportunities to support their transformation needs with in-person, virtual, and on-demand events and information. National and regional learning communities will provide CPC+ practices with opportunities for in-person and web-based learning. Learning events and materials will orient practices to CPC+ program requirements and guide practices through the CPC+ corridors of work. Online collaboration tools and web-based portals will facilitate practice sharing. Regional learning communities will also offer targeted, practice-level technical assistance to support practices to enhance their capabilities.

Q16: How will this model be evaluated?

A16: Like all models tested by CMS, there will be a formal, independent evaluation using quantitative and qualitative data to assess the impact and the implementation experience of each track of CPC+. Key beneficiary outcomes of interest will include both care quality and service use.

Q17: Can practices participate in both CPC+ and other CMS or Innovation Center models?

A17: Rules regarding practice participation in CPC+ and other CMS initiatives, models, or demonstrations are outlined as follows:

- Practices may not participate in other Medicare shared savings programs or demonstrations. This includes the Independence at Home demonstration, as well as Medicare accountable care organizations (ACOs), including the Medicare Shared Savings Program (MSSP) and Next Generation ACO.
- CPC+ practices may participate in Model 2 and Model 3 of the Bundled Payments for Care Improvement Initiative and the Oncology Care Model. While they would not be participants themselves, CPC+ practices may also engage in sharing arrangements with participant hospitals in the Comprehensive Care for Joint Replacement Model.
- Medicare beneficiaries may be attributed to both CPC+ and Million Hearts® Cardiovascular Disease Risk Reduction model practices, as cardiovascular interventions can be part of, and complementary to, practice transformation.
- Because of differences in payment in these two models, CPC+ practices may participate in the Accountable Health Communities Model.
- If payers engaging in a State Innovation Model (SIM) partner with CMS in CPC+, and states that have received SIM grants are selected as CPC+ regions, practices in these states may participate in CPC+.
- Participation in a Transforming Clinical Practice Initiative (TCPI) Practice Transformation Network or Support and Alignment Network is permitted for practices participating in CPC+; however, practices may not participate in learning activities provided through TCPI.

Q18: What happens to practices currently participating in CPC?

A18: The seven CPC regions will be included in CPC+ if sufficient payers indicate their interest in partnering in CPC+ and propose an aligned approach to CMS. If their region is selected to participate in CPC+, CPC practices are invited to apply directly to the track for which they are interested and believe they are eligible; however, CMS reserves the right to ask a practice that applied to Track 2 to instead participate in Track 1 if CMS believes that the practices does not meet the eligibility requirements for Track 2 but does meet the requirements for Track 1.

Q19: Are payers in states that have received State Innovation Model grants (SIM) allowed to partner in CPC+?

A19: The State Innovation Models (SIM) Initiative is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states. Some states are pursuing primary care transformation that closely resembles CPC+. States that have received Model Test Awards will be given preference in the selection of CPC+ regions, if sufficient payers submit proposals and meet the payer partnership standards enumerated above.

Q20: Are payers and practices in the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration allowed to partner in CPC+?

A20: MAPCP payers and practices are invited to partner in CPC+. In the initial payer solicitation round, CMS will give preference to the eight states that have participated in MAPCP, where Medicaid is a participating payer, if sufficient payers respond to the solicitation and propose an aligned approach to CMS. CMS intends to test the CPC+ care delivery and payment model, but acknowledges that the CPC+ design may vary from the primary care transformation framework developed by MAPCP states. If MAPCP states or applicable regions are selected as CPC+ regions, then MAPCP practices are invited to apply to the track for which they believe they are eligible.

Q21: Are practices eligible to bill the Medicare Chronic Care Management fee (CCM) if they are participating in CPC+?

A21: Because the CPC+ CMFs are intended to pay for covered CCM services, CPC+ participating practices cannot also bill for the same services using the CCM code under the Physician Fee Schedule. However, CPC+ practices may bill for covered CCM services under the Physician Fee Schedule if those services are provided to a Medicare beneficiary that is not attributed to that practice for purposes of the CPC+ model.

Q22: How does CPC+ impact the prospects of expanding the current CPC initiative?

A22: CPC+ was designed based on the lessons learned to date in CPC. Though CPC ends in December 2016, CMS will continue to consider all available data from CPC as it becomes available, including shared savings results, quality performance, and the results of the independent evaluation, to determine whether and/or when to scale the model in accordance with the statutory requirements for expansion under section 1115A of the Social Security Act.

Q23: How would this model be affected by the new Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation?

A23: The MACRA legislation contains payment incentives for practitioners who participate in alternative payment models that meet certain criteria. These criteria will be developed in forthcoming notice and comment rulemaking.

CPC
Comprehensive Primary Care

Milbank Memorial Fund

Nebraska Multi-payer Patient-Centered Medical Home stakeholder Group

Lisa Dulsky Watkins, MD
Director, Multi-State Collaborative
May 18, 2016

CPC
Comprehensive Primary Care

Milbank Memorial Fund

111 year old operating foundation

National scope

Neutral and bipartisan

"Improving Population Health by connecting leaders and decision makers with the best evidence and experience"

Milbank Memorial Fund Multi-State Collaborative

CPC
Comprehensive Primary Care

Members are actively engaged in multi-payer primary care transformation.

20 States or regions
1750 Primary Care practices
11,000 Primary Care providers
1,600,000 Medicare beneficiaries
8,000,000 total patients

Milbank Memorial Fund
Multi-State Collaborative 2016

CPC
Comprehensive Primary Care

MAPCP

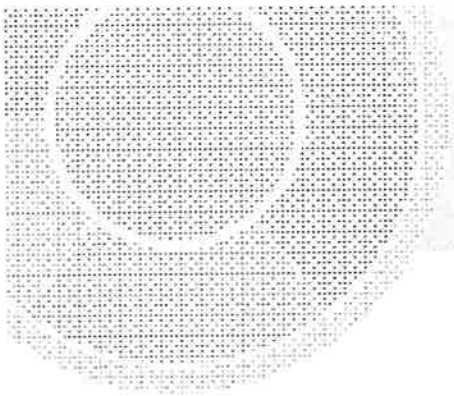
MAPCP and CPC

CPC

No CMMI Demonstration

Milbank Memorial Fund

Comprehensive Primary Care Plus | Center for Medicare & Medica

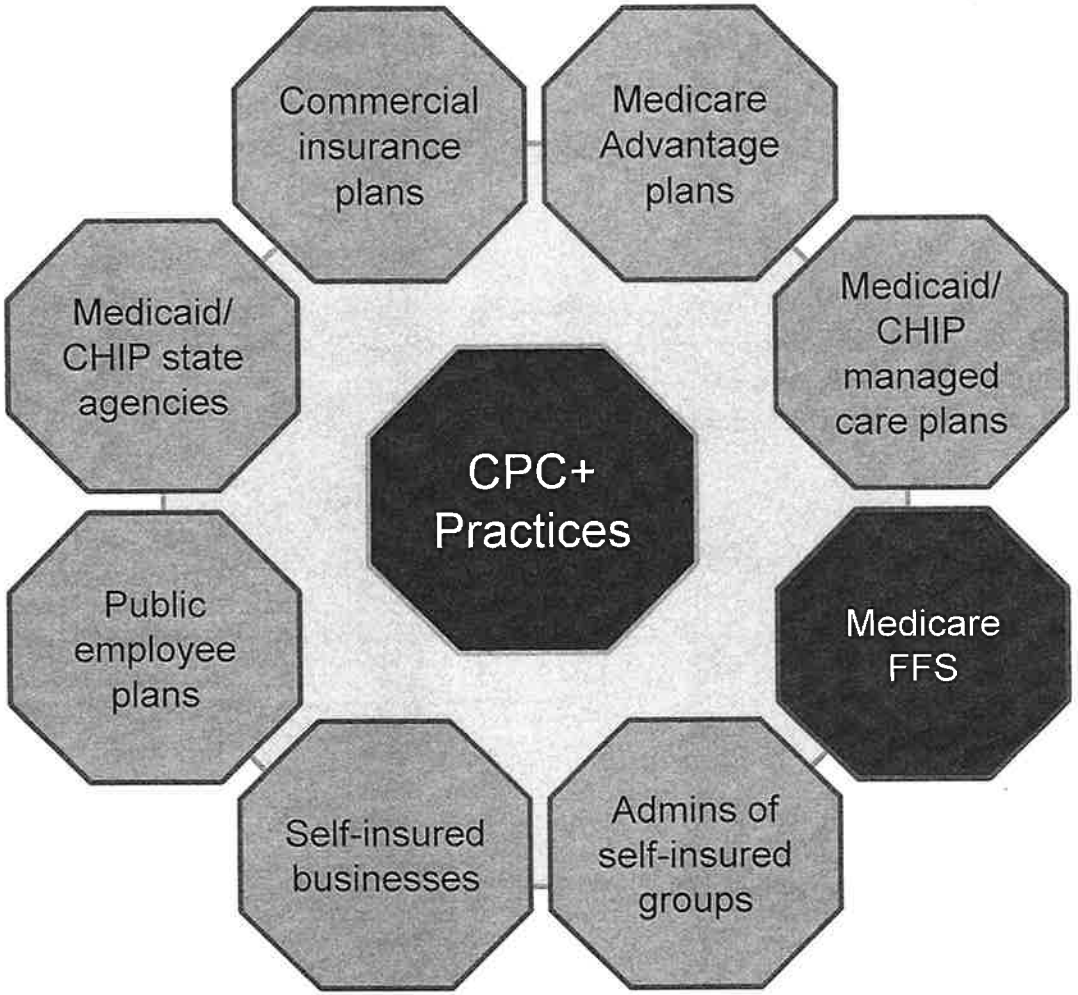


Comprehensive Primary Care Plus

Advancing the Delivery of
and Payment for Primary Care

Medicare Will Partner with Aligned Public and Private Payers

CMS is soliciting interested payer partners: April 15 – June 1, 2016



CPC+ Model Overview

CMS will solicit applications from practices within the regions chosen:
July 15 to September 1, 2016

5 Years

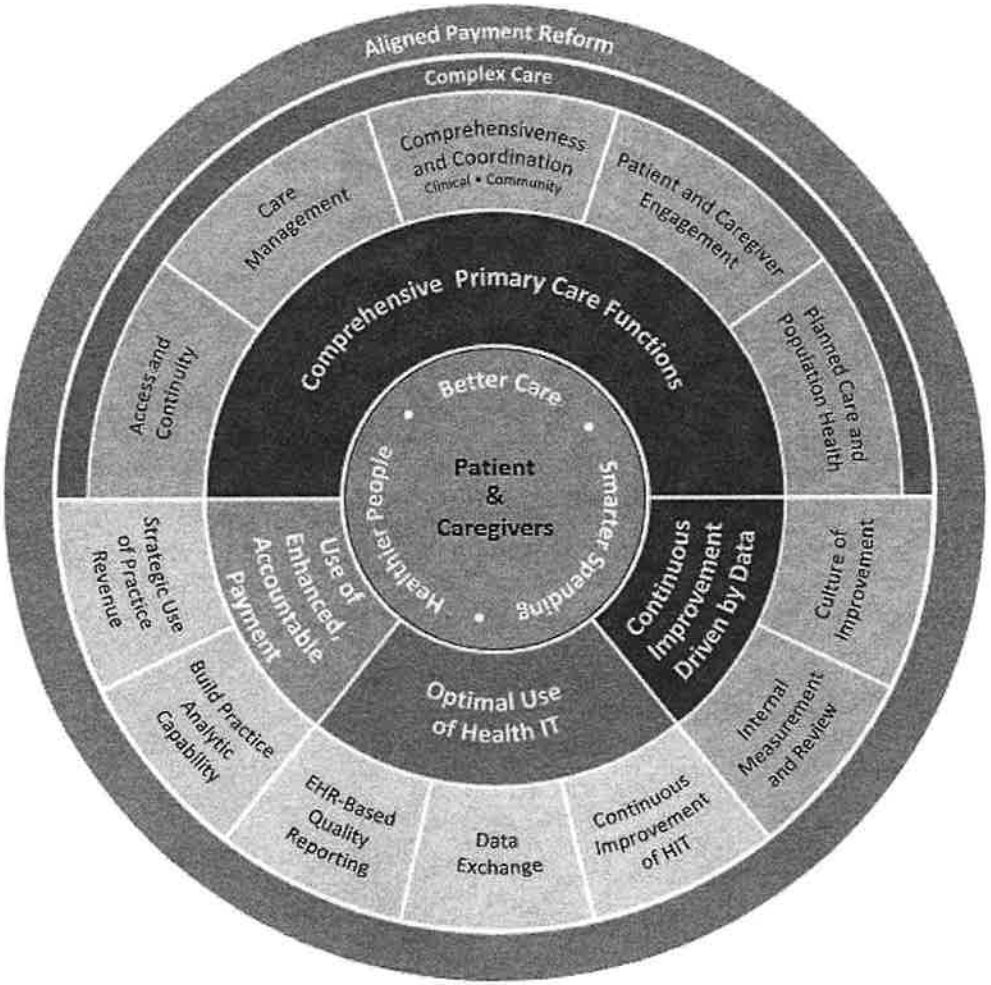
Beginning 2017, progress monitored quarterly

Up to 20 Regions

Selection based on payer interest and coverage

2 Program Tracks

Up to 2,500 practices in each track, based on practices' readiness for transformation



Framework for Payer Partnership

Enhanced, non-fee-for-service support for Track 1 and 2 practices to meet the aims of the care delivery model

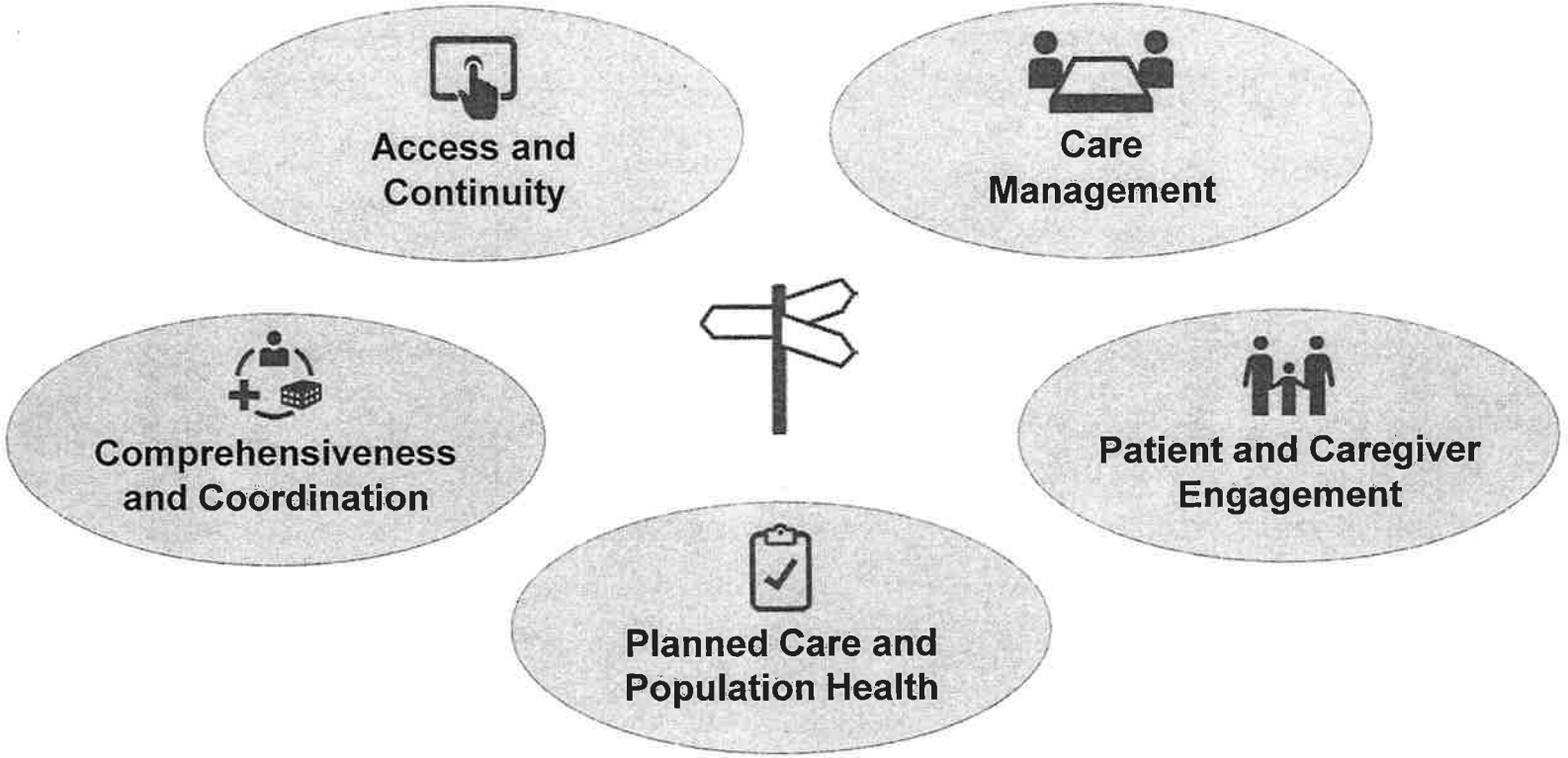
Change in cash flow mechanism from fee-for-service to at a least a **partial alternative payment methodology** for Track 2 practices

Performance-based incentive payments for Track 1 and 2 practices

Aligned **quality and patient experience measures** with Medicare FFS and other payers in the region

Practice and member-level **cost and utilization data** at regular intervals for all practices

CPC+ Functions Guide Transformation



Three Payment Innovations Support Practice Transformation

	Care Management Fee (PBPM)	Underlying Payment Structure	Performance-Based Incentive Payment
Track 1	$15 average	Standard FFS	$2.50 opportunity
Track 2	$28 average; including $100 to support patients with complex needs	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)	$4.00 opportunity

Program Overlaps and Synergies

Medicare Shared Savings Program

Practices **cannot participate** in CPC+ and a Medicare shared savings program or demonstration, including Medicare ACOs and the Independence at Home (IAH) demonstration.

SIM

If SIM payers partner on CPC+ and the state is selected as a region, then practices in these states **may participate** in CPC+.

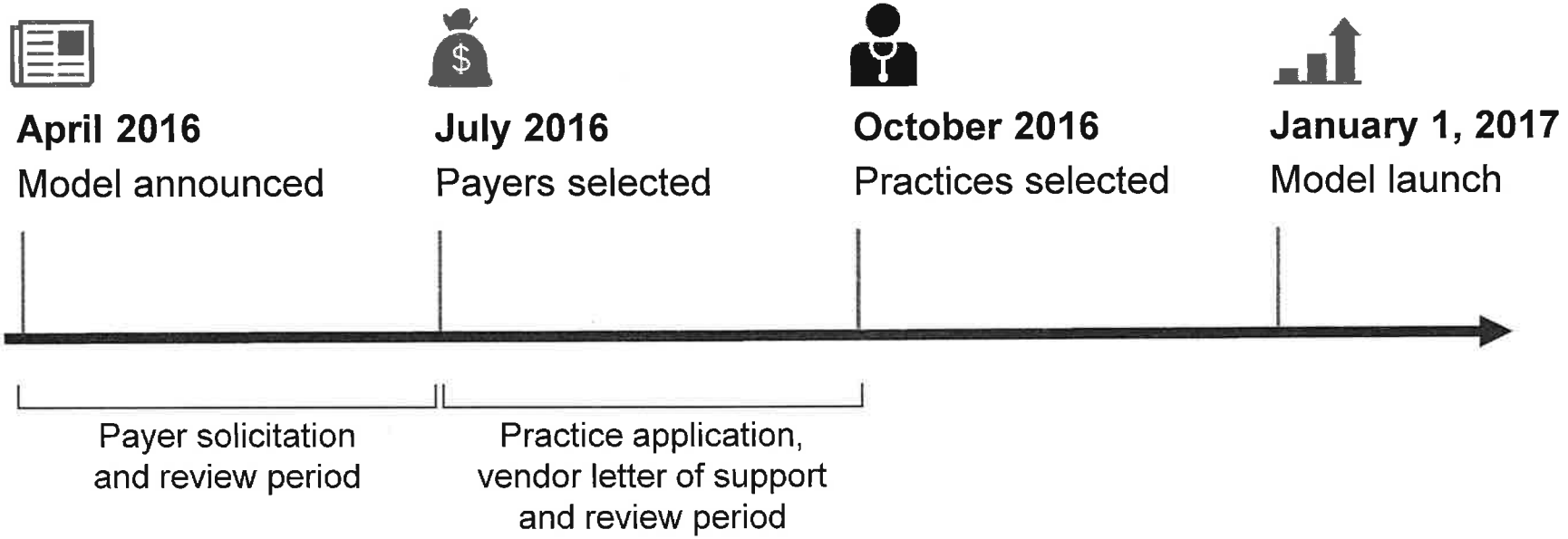
TCPI

Practices **may participate** in CPC+ if they act as faculty in a PTN/SAN but **may not participate** if they are recipients of learning activities. In effect, TCPI practices may "graduate" to CPC+.

AHC

Practices **may participate** in CPC+ and be paid by an AHC bridge organization (or be a bridge organization).

CPC+ Timeline to Launch



For more information:
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus